SITUATION ANALYSIS OF THE Social Protection Centres for People with Severe Mental Disorders under the management of the Ministry of Labour Invalids and Social Affairs

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The study was conducted by an joint team from RTCCD and MOLISA. The team has made every attempt to accurately reflect the facts and the views that have been provided to the research team. The team takes full responsibility for any errors of fact or omission, or for any inadvertent misrepresentation of material provided. For comments, please contact Dr. Tran Tuan at trantuanrtccd@gmail.com

SITUATION ANALYSIS
of the Social Protection Centres for People with Severe Mental Disorders

under the Management of the Ministry of Labour Invalids and Social Affairs

ABBREVIATIONS

BSP	Bureau of Social Protection
CP	Communist Party
DOH	(Provincial) Department of Health
DOLISA	(Provincial) Department of Labour, Invalid and Social Affairs
MOLISA	Ministry of Labour, Invalid and Social Affairs
MOH	Ministry of Health
NA	National Assembly, Vietnam
NCD	Non-communicable disease
NGO	Non-governmental organization
RTCCD	Research and Training Centre for Community Development
SPC	Social Protection Centre
UNICEF	United Nations Children's Fund
VUSTA	Vietnam Union of Science and Technology Associations
WHO	World Health Organization

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EXECUTIVE SUMMARY

This research was a collaboration between the Research and Training Centre for Community Development (RTCCD) and the Bureau of Social Protection (BSP) under the Ministry of Labor, Invalid and Social Affairs (MOLISA) with financial support from the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The aim of the study was to measure the gap between practical needs of mental patients and current response of the MOLISA mental healthcare system. The results can be used to determine future action within the National Mental Healthcare Action Plan of 2011-2020. Data were collected in three specific studies:

1) A review of laws and regulations at both the central level, with the source of information from MOLISA and the Ministry of Health (MOH), and the local level with information obtained from eight selected provinces/cities

2) An assessment of the current status of the MOLISA centers which are in charge of the care and protection of people with severe mental illness in eight surveyed provinces/cities; and

3) An assessment of the provision of community-based services providing care and social support to those affected by mental illness within the areas surveyed.

Data analysis involved a pooled effort from the research team and policy makers who work with social protection and rehabilitation for mentally ill patients at MOLISA. A strong collaboration in research activities and data analysis by policy makers and local researchers facilitated a transfer of research results to policy adjustments in a timely fashion. The research team has been continuously updating the changes in health care policy for mentally ill patients that were issued by MOLISA in 2011 in order to adjust the contents of the report.

The study ended up with five specific conclusions and five recommendations for action to be taken during the period 2012-13, and one in particular was to most strongly benefit WHO and UNICEF.

Conclusions

1. The mental healthcare system managed by the MOLISA consists of seventeen social protection centers in sixteen provinces. It is responsible for making national social protection policies that affect vulnerable populations, including mentally ill patients, in every commune in Vietnam. This system functions parallel to a MOH system which includes the National Institute of Mental Health, two national psychiatric hospitals, 32 provincial psychiatric hospitals, 33 psychiatric departments at provincial general hospitals and 33 psychiatric departments at provincial social disease centers, in addition to a national community-based mental healthcare program that is now functioning in 70% of the communes. The core activity of this program is the distribution of medication to identified schizophrenics and epileptics (diagnosed at either a provincial or a national psychiatric hospital) by communal healthcare centers.

2. There is a lack of a comprehensive mental healthcare national policy. This has resulted in a winding interaction between the MOLISA and the MOH systems, as can be seen in the national standard guideline package and the practical performance at the local level. Projects 32 and 1215 have created a context which invites collaboration amongst various agencies, particularly MOLISA and the MOH.

3. The mental healthcare system managed by MOLISA has the following noticeable features:

    a. The social protection and rehabilitation center for mental patients has acted as a physical institution which takes in patients who live in the street, who were ignored by their family members and relatives, who have no caretakers or who are members of a family that was recognized for its involvement in the struggle for the Independence of Vietnam. The centers exist in only sixteen provinces/cities (approximately 20% of provinces in Vietnam). At

present, these centers can provide less than one third of the mental healthcare needs of those residing within those provinces/cities. In the eight surveyed settings, it was discovered that the services that were jointly provided by MOLISA and the MOH has been devoid of professional standards. The network that has been established has provided nothing more then administrative and logistic management which includes referral and the discharge of patients. This situation may exist because of the lack of a regulation of professional activity and standards by the provincial healthcare system. It was found that 18.8% of the mentally ill patients surveyed are at present caged and or fettered at home because their families and communities, who would like to send them to the social protection centers, had their application requests denied.

b. While healthcare goals have been set by the Vietnam Communist Party (CP) and WHO has made healthcare and rehabilitation recommendations for people who suffer from mental health problems in developing countries in these early decades of the 21st century, the MOLISA system lacks even the basic resources that could meet the mental healthcare needs at either institutions or communities. All seventeen of the provincial centers face a severe shortage of necessary resources. While the human resources are enthusiastic about carry out their duties, they have not been professionally trained and they have not acquired information or skills needed or learned methodologies and they are unable to provide proper healthcare and rehabilitation for those who are mentally ill. The physical environment has not been designed or equipped to function as a mental healthcare rehabilitation facility and it therefore is not operated as such and cannot provide a patient-centered approach which respect their fundamental human rights. None of the surveyed facilities had been supplied with any technical guidelines and none of them were in communication or collaborating with their peers within the mental healthcare system or any other relevant system, and this was particularly the case regarding the MOH. Significantly, their budgets were so limited that they could provide housing services only and not mental health care or rehabilitation of the clients.

c. For the last five years, the MOLISA system has delivered social protection services as required by Decrees 67/2007/ND-CP issued on April 13, 2007 and 13/2010/ND-CP issued on February 27, 2010. These decrees include the provision of services to the mentally ill patients. By 2011, it was assessed that the system provides the basic services required by Decree 13 to mentally ill patients. However, according to the MOLISA's definition:, "a mentally ill person" is anyone who was treated at a psychiatric hospital. So, anyone who did not receive treatment at a psychiatric hospital is by definition 'not mentally ill'. Consequently, many people who are mentally ill are not a statistic of the MOH system and activities managed by the MOLISA ignore a large proportion of mentally ill people who need assistance.

d. It can be seen that the mental healthcare systems operated by either MOLISA or the MOH have given attention to psychotic disorders but it ignores such things as depression, anxiety, post traumatic stress disorder, disorders due to alcohol abuse or substance abuse, and particularly those mental disorders which are common in pregnant women, breastfeeding mothers, children and adolescents. Such care is not being provided for a number of reasons, the main one being the lack of an IEC program to provide basic information of staff members and citizens on the prevention, treatment and rehabilitation of mentally ill people.

4. There exists a plan to upgrade the system by implementing two national projects, one being "National Project 32/QD-TTg in reference to the development of social work," issued on March 25, 2010, and the other being "National Project 1215/QD-TTg in reference to community-based social support and rehabilitation for mentally ill patients and people with mental disorders period 2011-2020," issued on July 22, 2011. The possibility that these projects might be realized is a positive movement by MOLISA and it reflects a strong political determination of the Vietnamese government in the last two years to improve social equity and security in general and for the benefit of the mentally ill people in particular.

5. Due to a severe deficit of resources and cooperation between agencies and two new Projects 32 and 1215 (they are both still in the model establishment phase), there has been no substantial

improvement in the provision of mental healthcare since late 2010 when the research team collected the data. It is also obvious that the training bodies of MOLISA, the MOH and the Ministry of Education and Training are now even less able to provide on-the-job training to fill the gaps in profession within the MOLISA system at both community and provincial levels. Therefore, it is believed that the conclusions and recommendations that resulted from this study are pertinent and offer a good opportunity for MOLISA to adjust its priorities and schedule the implementation of Projects 32 and 1215 in the next two years (2012-13).

Recommendations for action

1. Establishing a vision and national action framework for mental healthcare in Vietnam should be given priority status in these next two years. Plans should be made to carry out the activities presented in Projects 32, Project 1215, the mental healthcare project within the National Target Program and Project 930/QD-TTg of June 30, 2009 (which addresses improving and establishing provincial psychiatric hospitals where that kind of hospital does not yet exist), to be run by MOLISA and the MOH. A taskforce group should be created to draw up the draft and introduce a national mental healthcare policy that can function with the existing resources of the nation and approximate WHO recommendations. The policy should facilitate the collaboration of ministries and local agencies to result in the creation of action plans that could function between now and 2020, with a goal being the forming an integrated multi-sectoral mental healthcare system of which the core component is preventative medicine, rehabilitation and community-based support activities for mentally ill people.

2. The National Assembly (NA) is encouraged to issue a resolution to extend the political imperative for MOLISA and the MOH to get together to build and implement one system of community-based mental healthcare at the grassroots level. Meanwhile, it is suggested that MOLISA's Projects 32 and 1215, the national target programs and MOH's Project 930 focus on an overall objective that would renovate the mental healthcare and rehabilitation system for the mentally ill people following WHO recommendations and with a goal of "equity, efficiency, and sustainability" in healthcare as set by the CP. If this direction is taken, each project would concentrate on specific objectives to form both an infrastructure and a management mechanism of the mental healthcare system in every province. These systems would function with the treatment and rehabilitation facilities and the community-based care regime.

3. Activities on mental healthcare in 2012 should be scheduled as follows:

    - To obtain agreement on the vision and action plan framework for the national mental healthcare policy. This is a high priority activity and every effort should be made to attract the participation of various organizations and multi-sector researchers.

    - To design a mental healthcare model that can function at the provincial level based on the strategies presented in Projects 32, 1215 and 930 and the national community-based mental healthcare program, as well as WHO recommendations. This model is to contain two components: (1) **A basic, community-based component** which is responsible for preventative medicine, early detection, early intervention and treatment and early rehabilitation. It is to be performed and controlled by a multi-sectoral workforce made up of social workers and health workers; (2) **A support component** consisting of care and treatment clinics which involves the cooperation of the psychiatric hospitals with consideration for social protection for mentally ill patients. There should be one clinic in each province that can diagnose, treat, care for and rehabilitate severe psychiatric cases.

    - To plan and introduce an integrated mental healthcare model at the primary level (district or commune), piloted in one district.

4. It is suggested that a technical support group be established containing national experts with experience in multi-sectoral consultancy or those who specialize in mental healthcare, to link and backup the activities run by MOLISA and the MOH. This think tank should be formed and

coordinated by VUSTA because its role as assigned by the NA and the Vietnamese government is to provide technical consultancy and critical review for the development of programs and projects.

5. The support of UNICEF and WHO is indispensable and this should be promoted using three approaches:

   - Help relevant ministries to agree on a holistic and community-based approach in mental healthcare and to give priority to models and initiatives which are based on research evidence and are appropriate when considering the existing resources of the country.

   - Foster the establishment and operation of the technical support group while also advocating for the swift creation of political and legislative framework on mental healthcare in Vietnam. Workshops and pilot studies to collect evidence for policy-orientation should be endorsed in 2012-13.

   - Provide consultancy to VUSTA to help them establish and run mental healthcare think tank and ensure its role as a scientific and independent voice that will influence policy review of relevant law makers (the NA Committee for Social Affairs, the Department of Social Affairs of the Commission for Ideology of Communist Party, MOLISA, MOH and Ministry of Finance).

   - Strengthen the involvement of civil society organizations in the area of mental healthcare by providing them with technical and financial aid so that they can establish and pilot policy-oriented models, fund workshops and engage in policy advocacy activities making use of evidence obtained in field studies and human resource training.

PART 1
METHODOLOGY

1. INTRODUCTION

The mental healthcare system in Vietnam is mainly operated by the MOH and the MOLISA. The MOLISA provides care and rehabilitation services undertaken by "social workers"[1] at the community and by the social protection centres (SPCs) for people with severe mental disorders established in 16 provinces.

Towards the goal of "equity, efficiency, and sustainability" in the mental healthcare system, the MOLISA, in collaboration with the UNICEF and the WHO, are developing a mental health action plan 2011-15. To ensure that the intended program is appropriate for the community needs, an analysis of current situation of the mental healthcare system managed by the MOLISA, conducted by related agencies, is required.

The initial suggestion recommneded by a technical advisor of the WHO was to introduce a holistic system research[2] on eight core areas (Box 1). Each area employs a particular study. However, during the discussion to put the research into practice, the Bureau of Social Protection agreed to launch only one research, based on the limited resources of human and finance (supported by the WHO in 2010-11). This unique research is to understand the structure and operation of the current systems on mental healthcare at the macro level (an analysis of the current policies) and at the locals where there have or have not gotten the SPCs for mental patients. The research outputs will plan strategic priorities for a system reform in the coming years. In the future, while the project 32 develops social work, the social protection system for mental sufferes will be renewed and launched at both curative and community areas (Box 2).

Box 1: Study components of the mental healthcare system assessment to improve mental healthcare system managed by the MOLISA

1. To review laws and regulations relevant to the treatment and support for people with mental disorders;
2. To analyze the current policies and guidelines of policy implementation;
3. To analyze the current government spending on mental health facilities (at both central and local levels);
4. To comprehensively analyze current conditions and services provided by the MOLISA system;
5. To analyze the current workforce of the MOLISA centres;
6. To have the geographic mapping of financial, physical and human resources for mental healthcare;
7. To investigate the distribution of patients, by mental health status, level of disabilities, and needs on mental healthcare;
8. To expose the number and characteristics of users who is receiving the services provided by the MOLISA and the MOH systems at different levels.

The data collection had the participation of researchers from the RTCCD and the BSP (MOLISA), conducted from September 2010 to April 2011.

[1] They are defined as community workers who provide social protection services to beneficiaries (including mental patients) as decided by the Decree 67/2007/ND-CP issued on 13th April 2007 and Decree 13/2010/ND-CP issued on 27th February 2010. The term "social worker" has been recently used, particularly after launching the project 32 to develop social work in Vietnam.

[2] Harry Minas (2010). Reform of the system of MOLISA centres for persons with severe mental disorders; Briefing notes for meeting at MOLISA on 16 July 2009; Preliminary thoughts.

Box 2: Strategies on improvement and development of the social protection and support system for mental people coordinated by the MOLISA

- Existing SPCs for severe mental patients is necessary to be improved in reference of service quality and patient right-based approach. WHO recommendations on care and prevention of problem reoccurence for mental sufferers in developing countries will be applied in the operation procedure of the centres
- Community care and protection system, a component of social work system run by the MOLISA, will be coordinated based on practical social support principles on prevention and treatment of mental disorders at the community level.

2. STUDY OBJECTIVES

The research analyzes the existing social protection run by the MOLISA for beneficiaries who are mentally ill, in connection with mental healthcare system run by the MOH. It gathers the following specific objectives:

1. To review laws and regulations relevant to the treatment and support for people with mental problems;
2. To analyze the current policies and guidelines of policy implementation;
3. To analyze the current government spending on social protection system for mental patients;
4. To comprehensively analyze current conditions and services provided by the social protection centres;
5. To analyze the current workforce of the MOLISA centres and working at the community;
6. To assess the physical environment of the centres;
7. To investigate the distribution of patients, by mental health status, level of gravity, and needs on social protection patterns provided by the MOLISA system;
8. To expose the characteristics of users who is receiving the services provided by the MOLISA, in comparison to those who is cared by the MOH systems.

3. STUDY DESIGN[3]

3.1. Study subjects and methodology

The study applied both qualitative and quantitative measures to collect data from three levels: ministerial, provincial, and community (Box 3). The four main groups of informants were managers, health personnels, district/communal social workers, and patients' families (Box 3).

Box 3: Sources of data

- ***ministry level*** (for reviewing mental health policies and planning - objectives 1, 2, 3, 5 and 6);
- ***provincial level*** (for assessing mental health institution capacity and care needs of patients - objectives 3, 4, 6, 7, and 8); and
- ***community level*** (for investigating community-based resources for mental health care as well as care needs of patients at the community level - objectives 3 and 8).

3.2. Sampling

The study enrolled a multi-stage sampling, combined by purposive sampling and random sampling. The first step of sample selection – purpose sampling – picked up five provinces which have SPCs for

[3] Two phasal reports, which were sent to WHO when proposal design and data collection were due, details design of the study and fieldwork ogranization. Therefore, this report summarizes main points to help the audience comprehend backgrounds of the research findings. For further details, please contact the research team or WHO office in Hanoi to get these reports.

mental people and three control ones which have not got that kind of centres, considering the BSP suggestion, in order to have a critical review of the system. The selected provinces were:

- **Hanoi** – representing big cities where resources are most available;
- **Da Nang**[4] - one of the two cities has had international supports to improve the provincial mental health system following community-based approach;
- three provinces have social protection centres, representing three regional areas of Vietnam, were: **Son La** (northern), **Binh Dinh** (central coast) and **Ben Tre** (Mekong delta); and
- three control provinces with no social protection centres: **Quang Ngai** (central coast), **Dak Lak** (central highland), and **Kien Giang** (Mekong delta).

In the second step at every province, the whole social protection system at all levels was assessed, including social protection centre, psychiatric hospital, and mental healthcare network. The participants srecruited includemanagers and patients' families..Finally, six communes were selected in each province. At every commune, social protection workers, mental healthcare staff, and households having mental relatives were invited to participate in the study. Box 4 indicate groups of study informants of the study.

Box 4: Informants

- ***Managers***: ministry officials (MOLISA and MOH), provincial officials (MOLISA centres or hospitals for psychiatrics), and local government staff. They were asked about the process of formulating national policies and guidelines to support the mental healthcare activities, planning, human and financial resources to implement those plans.
- ***Health personnel*****:** those who provided routine care for patients in the MOLISA centres and community mental healthcare projects (staff of communal and district health centres).
- ***Community social workers:*** those who directly provide social supports to mentally-ill patients.
- ***Patients and their families*****:** those who have had mental healthcare needs and were cared by the MOLISA or the MOH systems (both adults and children)

In summary, 244 household interviews, 137 quantitative interviews with communal social protection and mental healthcare staff, and 69 qualitative ones with communal social protection workers were conducted in 48 communes. At higher level, qualitative in-depth interviews were replied by 68 managers of the MOLISA and MOH systems, 22 leaders of social protection centrers, 68 staff who were providing rountine care for patients, and 56 patients' relatives at psychiatric facilities.

Annex 1 presents number of informants, by province and study groups.

3.3. Study components and fieldwork organization

BSP and RTCCD were in chief of data collection organization at the central level. The joint research team also had strong collaboration of DOLISA in the fieldwork.

[4] Da Nang and Khanh Hoa have been supporting by the Atlantic Philanthropies through VVAF to improve provincial mental healthcare systems following community-based mental healthcare approach, initiated in 2006 and will due by 2012 (See more details on the technical report on mental healthcare models run by NGOs sent to UNICEF on October 2011).

All qualitative and quantitative data were collected upon three specific studies:

- **Component 1: An analysis of mental healthcare policies in Vietnam and the role of the MOLISA** using secondary data from the MOLISA and MOH's offices, as well as in-depth interviews conducted with in-charge staff at every level. This component aimed mostly to meet objectives 1, 2, and 3.
- **Component 2: A systemic analysis of the MOLISA centres**, using both quantitative and qualitative research tools to understand their current state, services provided, clients, human resources, service provision capacity, infrastructure, and sources of funding. This component aimed to reach objectives 3, 4, 5, and 6.
- **Component 3: An assessment of patients' mental healthcare** needs (particularly of women, children and elderly) **and of community support5 to mental patients**, using both quantitative and qualitative tools to reach objectives 7 and 8.

In terms of research tools, a total of 10 forms were developed, where five were for qualitative interviews[6], three were descriptive report forms[7], and two were quantitative forms for households, community social protection and health staff.

[5] Apart from mental healthcare systems operated by the MOLISA and community program done by the MOH, mental healthcare models run by VNGOs and INGOs were already assessed by MOLISA-WHO-UNICEF-RTCCD research team.

[6] Form A1 (Policy makers and leaders of DOLISA, psychiatric hospitals and mental health facilities); B1 (leaders/specialized staff of social protection centres/05/06 centres/psychiatric departments of general hospitals); B1b (staff/workers provides routine care for patients); B2 (relatives of patients who are living in social protection centres/health facilities); and C1 (qualitative interview with social protection workers).

[7] Form B3a (Descriptive form for social protection centres/05/06 centre); B3b (Descriptive form for provincial hospital of psychiatrics, department of psychiatrics); and B4 (check-list on MHC quality). For more details of forms, see technical report sent to the WHO on September 2010.

PART 2
FINDINGS

This report presents findings in six chapters. Chapter 1 analyzes mental health policies in Vietnam and the role of the MOLISA in mental healthcare. Chapter 2 describes government spending on mental healthcare. Chapter 3 explains the operation of the MOLISA centres in relation to the mental healthcare system which is being managed by the MOH. Chapter 4 depicts the social protection workforce in the mental healthcare area and their challenges. The fifth chapter expresses the community needs on mental healthcare. And the last one summarizes research recommendations and policy implications.

CHAPTER 1

Mental Health Policies in Vietnam and the Roles of MOLISA in Mental Healthcare

1. National policy framework on the care for people with mental problems and systematic interventions for patients' care

Understanding that a national policy on mental healthcare is a documentation in which it *"describes the values, objectives and strategies of the government to reduce the mental health burden and to improve mental health"* [1], no official documents published by either the MOH or the MOLISA are proper enough to be considered as a "national policy on mental healthcare" to date. This comment may be seen as "rigid", because there is an existence of a hospital and social protection system providing care for mental patients, plus a community network which has the main function of delivering medication and financial support to patients, operated by two ministries for years.

Nevertheless, to strengthen the research team's persepective, we remind the WHO practical definition of policies [1] (Box 5) which has been considered as a standard one to help us objectively evaluate the situation of the mental health policies in Vietnam.

Box 5: Operational definition of policies (WHO, 2001)

Policies specify the standards that need to be applied across all programmes and services, linking them all with a common vision, objectives and purpose. Without this overall connection, programme and services are likely to be inefficient and fragmented [1].

In fact, the MOH agreed that this national policy is of inadequate, illustrated by two suggestions (Box 6) stated in a presentation provided by its representative in the workshop on 6th August 2010 organized by the NA.

Up to date, Vietnam is one among 35 countries who does not have any laws or ordinances on mental healthcare. The 1989 law on people's health protection confirms that every citizen has the rights to be protected towards health problems, to be on rest, to enjoy recreation, to do physical exercises, to be guaranteed labour safety, food safety and hygiene, and clean environmental conditions, and to be served by health workers [2], but no article in that law associated with mental healthcare is mentioned.

In addition to the national projects which have directly contributed to the development of the mental healthcare system, those policies provide an overview of the current situation on mental healthcare legislation in Vietnam (Box 7).

Box 6: The MOH's suggestions and recommendations

At the workshop "Southern governors with health policies and legislation" co-organized by the NA Committee for Social Affairs (Term XII) and the VUSTA on 6th August 2010.

- Develop and launch a national policy on mental healthcare
- Strengthen the supervision of the NA and promulgate an official decree on mental healthcare (if neccessary)

Box 7: Existing policies and legislation related to people with mental problems

- ***Support for vulnerable persons who need social protection (Decree 13/2010)***: introduces monthly allowance aides to people with schizophrenia and other mental disorders who have already been experiencing multiple treatment without any improvement in facilities for psychiatrics.
- ***Law on the disabled (2010):*** defines the mentally-ill people and those who have neurological errors as the disabled. It creates a legal foundation to frame the patients as the beneficiary of government aids (Decree 13).
- ***Law on examination and treatment (2009):*** declares that treatment of mental problems, including professionals' consultation and patients' profile management is obligated.
- ***Law on the elderly (2009):*** requires services for physical and mental care needs of the elderly. It also introduces the policies and regulations on care for older people with physical and mental disabilities.
- ***Law on child care, education and protection (2006)***: agrees child's rights and the responsibilities of the Government, mass organizations, community and families on care for children with special needs, including orphans, abandoned children, physically- and mentally-ill children, children with HIV/AIDS and agent orange.
- ***Law on health insurance (63/2005/ND-CP)***: assigns a compulsory provision of health insurance to social protection targets, including mental illness sufferers, who have already received monthly allowance.
- ***Code of criminal procedure (2003)***: designates that a mentally-ill person is not appropriate to be a witness. A case which involves a mentally-ill arrestee will be completely or temporarily suspended. Forced treatment to prisoners having mental disorders is obligated.
- ***The marriage and family law (2000)***: Parents have the joint obligation and right to care for and raise their juvenile or adult children who are disabled, have lost their civil capacity to act, are incapable to work and have no property to support themselves…. and children have the obligation to care for and support their parents, especially when they are sick, become senile or disabled. The law also states parents/children's rights of management sick or disabled children/parents's properties.
- ***Law on drug control (2000)***: details the management of drug, addictives, and psychotropic medication.
- ***Decree on judicial forensics (2004)***: requires the regulations of establishment of a mental health forensic centre.
- ***Law on pharmeceutics (2005)***: regulates the management of addictives, psychotropic medication and ingredient for psychotropic medications.
- ***Community mental healthcare project***, as a national target program coordinated by MOH (initiated in 1999): aims to ensure a continous treatment provided at the community for schizophrenia and epilepsy patients who were diagnosed by central/provincial hospitals for psychiatrics.
- ***The integrated model for non-communicable disease (NCD) prevention and control***, coordinated by the MOH (initiated in 2002): managed five NCDs, including mental illness.
- ***The project conducted according to the Decree 930/QD-TTg*** issued on 30th June 2009 in reference to "building and upgrading hospitals for tubeculosis, psychiatrics, cancers and tumours, and paediatrics, as well as general hospitals in the disadvantaged mountainous areas, using state bond and other legal funding period 2009-13".
- ***The project conducted according to the Decree 32/QD-TTg*** issued on 15th March 2010 in reference to "social work development in Vietnam", including social work in healthcare.
- ***The project conducted according to the Decree 1215/QD-TTg*** issued on 22nd July 2011 in reference to "community-based social support and rehabilitation to mental patients and people with mental disorders period 2011-2020".

It is clear that in the recent three years (2009-11), the Government approved two national projects (930 and 1215) with direct focus on mental healthcare managed by the MOLISA, and one (32) indirectly focused on this area and is controlled by the MOH. This demonstrates a significant movement in mental healthcare direction of the Vietnamese Government.

2. The roles of two key ministries (MOLISA and MOH) in implementing mental health policies

2.1. The roles of the MOH and the questions to the MOLISA

This section provides a further analysis on three projects run by the two key ministries (MOH and MOLISA) which directly relates to care and rehabilitation for mental sufferers to help the audience clearly envisage the risks of potential fragmentation of resources available for mental healthcare in Vietnam. The existing risks have resulted from a lack of a national framework on mental health. The analysis will additionally point out the promising contributions of the MOLISA for mental healthcare system in the country.

- *The community mental healthcare project* was piloted in 1999, and was formally launched in 2001. The program focuses on delivering psychiatric medication performed by community health collaborators to schizophrenia and epilepsy patients who have patient files set up by the provincial or central hospitals for psychiatrics. By 2010, the project covered 7,700 out of 10,997 communes all over the country, covering 70% of the whole communes. Since 2006, it has extended its scope to manage depression in some piloted communes [3] [4]. The project was evaluated by the RTCCD in 2008, having requested by both the MOH and the WHO, and receiving technical support from the WHO. The evaluation ended up with six conclusions and six recommendations for the implementers to improve the project (see Annex 2). However, the project team has not applied any strategic changes as recommended by the evaluation research, until the implementation of this study as well as until when the MOH's presentation in front of the NA Committee for Social Affairs meeting on collecting suggestions for the national target programs organized in 8th March 2011.

- *The integrated model for NCD prevention and control:* was started in 2002, controled by the Department of Medical Service Administration (MOH). In 2002-10, the program managed four diseases, e.g. hypertension, diabetes, cancer and mental illness, and was solely operated by the MOH's agencies without any intersectoral collaboration with other minitries, such as the MOLISA. The pilot program was

initiated in Thai Nguyen in 2007, the component of mental healthcare however was not launched until 2010 [5].

» *The project 930*: plans to upgrade and construct psychiatric hospitals in a number of provinces. The budget used in mental healthcare thus can substainably grow to invest in this section, bringing about a sharp increase in health personnels working in the curative area. For this reason, the human resources for mental healthcare, which is in a poor condition at the moment, may become worse in the coming years.

The analysis of the three MOH projects show that the MOH mental healthcare system is being reformed, considering hospital-based management and psychiatric medication utilization as the core of the system.

Psychological therapies, non-medication treatment and community support and rehabilitation have not been introduced in every province. The inappropriate MOH's systematic vision towards community mental healthcare, resource limitation, and the absence of the recommended application for improvement may be seen as the main causes of the failure of introduction of mental illness management. Consequently, the MOLISA actions on mental healthcare in the next period may experience a certain number of difficulties, if no systematic vision will be agreed between the two minitries. To reach this agreement, an intervention, which may be in a form of policy guideline, from the outter environment is required. In the current context, these guidelines on mental healthcare strategies for Vietnam should be issued by the CP, the NA and the VUSTA. They are an orientation document provided by the Vietnam CP, a resolution issued by the NA and a technical consultation provided by a ministry-level organization – the VUSTA. The shortage of every section of this trio can make challenges for the formulation of a national policy on mental health, as a foundation for the development of law on mental health and action framework for national projects relevant to mental health in the future.

2.2. The roles of the MOLISA in mental patients' care and supports

By July 2011, there have been two Decrees 13[6] and 68[7] robustly associated with the benefits of mental illness sufferers and the quality of care for people with mental disorders, in charge of the MOLISA to implement. The birth of the two projects 1215 and 32 will produce remarkable changes, which will be mentioned in later passages.

Amongst existing policies related to mental patients, the Decree 13 (modified from the Decree 67 – Supports for social protection targets) have created a great impact on mental healthcare activities at both community level (undertaken by the families) and provincial level (done by rehabilitation centres). The impact has manifested in two forms: the amount of monthly allowance paid for the clients, and the complexity of registration processes to enter mental rehabilitation centres managed by the DOLISA.

According to the Decree 13, mentally-ill people living in the community cared by families and local authorities receives a monthly payment of 270 thousand VND. Those who are residing in SPCs are provided with 450 thousand per month450,000 đ□ng[8]. They are issued health insurance card (as stated at the Decree 63/2005/ND-CP) to use healthcare services at public facilities free-of-charge.

In addition, the Decree 68/2008/ND-CP, which regulates criteria and processes of establishment, organization, operation and dismissal of a social protection centre, hassignificantly effected the quality of care for the mental patients and the centre infrastructure and caregivers' remuneration.

[8] The research team tried to explore the evidence of providing of 450 thousand as monthly allowance for mental clients who are living in the social protection centres and of 270 thousand for those who are being taken care at homes. But no clue is available and eligible to explain them adequately. Factual operations and leaders' opinion admitted that this payment is able to cover not larger than 70% of basic nutritional need for a patient 15 thousand per person-day). Therefore, when definition of mental problems will not be limited as psychotic disorders and patients' rights are respected at a basic level (including to be served with adequate nutritional care), the payment must increase double or triple, given that the same model of social protection centre is maintained.

On 22nd July 2011, the Prime Minister approved a national project proposal on "Community-based social support and rehabilitation for mental patients and people with mental disorders period 2011-2020" submitted by the MOLISA in the Decision 1215/QD-TTg – *hereinafter called as project 1215*. The project has an objective of by 2020 having 90% of street mental patients and those who are an endanger to their families and community will be cared between in-patient mental health services at social protection centre and the family care, 90% of people suffering from mental disorders receives psychological counselling services and other social ones, and 100% of families having mentally-ill members and 70% of patients gets awareness-raising training and support from community-based models. The project is in the planning phase to prepare activities in the period 2012-15.

The research team would express not the objective but a different approach of the MOLISA project, compared with the MOH objectives. The MOLISA ascertains an extended definition of mental people, including both "mental patients" – similar to the MOH's targets, and "people with mental disorders" – for instance persons with depression, anxiety, behavioral disorders, and substance abuse who is being ignored in the MOH "community mental health program" implemented during the last 10 years. These identified people will be the targets of their systematic intervention per WHO recommendations, which the MOLISA will apply a "community-based mental healthcare model" following the guidelines. All of these changes may prompt a new appearance of the Vietnamese mental health system in the future.

Social Work in Healthcare
Social Work in Mental Healthcare

The development of an advanced project, the 32, provides a good signal for strategic approach of the subsequent project 1215. It aspires to create social work occupation in Vietnam, including "social work in healthcare". This project was spawn when the MOLISA and the MOH realized a systemic shortage resulted from an inapt consideration on social work. Generally in Vietnam, social work has not been perceived as an official job which engages typical profession, skills and targets, particularly useful in social-related sciences, including healthcare. The practices of health workers, mass organizations and the MOLISA staff to provide mental healthcare currently are good at having providers' will and determination emotionally, but limitedly applied professional requirements of "social science" skills in healthcare. The MOH is the agency who recognized a need to reform within its sector regarding perspectives on healthcare provision, and that of employing social workers working for curative system to enhance the quality of services.

The presentations on "Social work in healthcare" and "Social work in mental healthcare" delivered in the workshop hosted by the MOH, with support from the UNICEF in July 2010, offered scientific evidence and reinforced determination of the MOLISA about the fitting of the project 32. After that, the MOLISA decided to choose mental healthcare to be its action scheme, expressed by the introduction of the project 1215. In a certain context, it can be said that the new approach of the project 1215 was kicked off by the MOH, but subsequently they did not directly make actions to do the reform. The underlying cause of this hesitation was the "domination" of psychiatrists from institutes, universities and leading hospitals whom robustly involve in forming the vision of the MOH on mental healthcare. In this viewpoint, mental healthcare in Vietnam – a sector obviously requires inter-sectoral cooperation – will beimproved when the MOLISA takes the lead. At the same time, the MOH is responsible for medical care, an important phase of care for mental sufferers but it is will also requires consistency in prevention of mental disorders, care, treatment, and rehabilitation.

It would be best to have the collaboration of the MOLISA and the MOH for a common purpose to bring Vietnam up to the international standards of mental healthcare practices as recommended by the WHO.

3. Barriers of mental health policy implementation

3.1. Barriers of the implementation of the Decree 13

The Decree 13 decides a raise of monthly allowance for mental patients, bringing happiness to patients' families and the SPCs. However, the inclusion criteria are not easy for families living in remote areas to assess.

The joint circular 24/2010/TTLT-BLDTBXH-BTC provides guidelines to implement a certain number of articles of the Decrees 67 and 13 issued by the Government in reference to supports for social protection targets, in which determines that application package to mental rehabilitation centres should include:

Application package:

- Application form, authorized by Communal People's Committee
- Curriculum Vitae
- Two passport-sized photos
- A letter of introduction issued by authorized healthcare facilities affiliated with mental healthcare (in case of the provinces not having hospital for psychiatrics, patients must have profile signed by the national hospitals for psychiatrics)
- A letter of reference signed by the District/City People's Committee
- A letter of acceptance signed by the director of rehabilitation centre

Authorized agency dealing with administrative procedures:

- Communal DOLISA accepts, confirms and sends the certified profiles to the DOLISA to re-check and approve.

Fee: Free-of-charge

The supporting documents may not be easily obtained by patients living in remote areas where there is no psychiatric hospitals. To meet the requirement of *having patient's file signed by the national hospitals for psychiatrics* is sometimes unaffordable for poor families to send their relatives to be examined and diagnosed at the national hospitals [8].

Moreover, the inclusion criteria to select mental people to enter centres or to receive social aids are not suitable:

- People with mental retardation are not included, as unclear operational definition of people with mental illnesses applied in the Decree 13[9].
- At present, clients of mental rehabilitation centres will receive care for their whole life. If a patient discharges/is discharged, the DOLISA will delete his/her name from the target list. Once it is done, the patient has to restart the entire application procedures if s/he needs to be re-admitted to the centre. This is a huge challenge for patient's family. The application process intangibly fosters families, particularly the poor ones, to leave their relatives staying at the centres in a prolonged period to get the life-care.
- The budget calculated and allocated to SPCs based on the volume of patients/beds – similarly to which is being applied in the hospitals of the health systems, forces the centres to maintain a satisfactory number of patients for the purpose of getting fundings for sustainability. In general, the budget of a SPC is limited, because the allowance per patients is low, at the same time, it is difficult for them to introduce service-based treatment, as MH patients often come from poor families.

Being stuck with budgeting criteria and complex registration procedures, the SPCs are less capable to function as their designated roles of providing care and rehabilitation for mentally-ill people. This struggle also impedes the implementation of community mental healthcare strategies, as well as is an obstacle to the goal of generating the collaboration between professional facilities (provincial psychiatric hospital managed by the DOH and SPC managed by the DOLISA within a province) and the social workers and families.

[9] The article 5 in chapter 4 of the Decree 13 declares that "Schizophrenia and mental disorder people were diagnosed by psychiatric facitilies and have experienced multiple treatment without significant improvements"

4. The national projects 1215 and 32: opportunities and challenges

The national project 1215 illustrates a political determination of the CP and the Government in improving the quality of care for people with mental illnesses. It is being regarded as a leap in mental healthcare in Vietnam. The project applies the full definition of people with mental problems, which enrolls people with severe mental illnesses to social protection centres, and those with mental disorders (mild types) to the community mental healthcare facilities. The project proposal indicates the source of funds, mainly be domestic, where 3,340 billions VND – i.e. 2,440 billions from central budget and 900 billions from local budget – accounted for approximately 40% (3,340/8,382) of the total budget, the remaining 60% (5,000/8,382) paid by patients' families. This is the first time a national project in a new area of healthcare, is entirely independent to international aids. Another opportunity of the project 1215 is to coordinated with the MOLISA, who is responsible for the project 32.

The project 32 aims at improving the quality of supports for vulnerable groups through training social workers, collaborators at all levels, and strengthen the

There are many challenges for the two projects with human resources among the top priority

organizational protocols in providing social supports and welfare to patients. In regards of the project budget, the State Fund guarantees to supply 1,294.4 billion VND, in which 497.3 billion was a part of budget for the MOLISA operations and 1,120 billion will be taken from local budgets. ODA and other international funds provide 65 billion. People with mental disorders and illnesses are identified as vulnerable groups; therefore, they are targets of social work duties. As a consequence, the implementation of the project 32 acts as a foundation for basic framework in the development of community mental healthcare activities. When it concurrently launched together with the project 1215, they will engender typical training activities. Consequently, human workforce of the MOLISA at every level working for mental healthcare will be maintained.

However, there are many challenges for the two projects with human resources among the top priority. Both projectsare developed in Vietnam, where a lack of social work teachers, training curriculum, field test and pilot models exists. At the moment, the international community does not give enough concern to this issue in Vietnam. It should be recognized that even though when they care for it, the assistance will be in the form of strategic orientation and direction only, since the mental healthcare owns the sociocultural features which require the rigorous involvement of local experts to solve the problems. For this reason, the quality and success of the implementation of the projects 32 and 1215 predominently depend on the level of participation of national experts' consultation, and collaboration between sectors and ministries (particularly the MOLISA and the MOH), and between the governmental agencies and local NGOs. There are promising examples on mental healthcare models created by VNGOs (see further details on the assessment report of mental healthcare models run by NGOs in Vietnam) may provoke a success if they are employed to scale-up by the MOLISA. A genuine "community-based mental healthcare" model calls for a multi-sectoral human workforce allocated to each district. These personnels will consist of trained social workers for mental healthcare, working in collaboration with health

staff. While training health personnels on “community mental healthcare” is still a serious shortage within the health system, there are enomous challenges for LISA sector in the pathway to reach the objectives of the project 1215.

Generally speaking, information and data interpretation presented in the first chapter tell us that the laws, decrees and projects have considered the mental sufferers as special cases, belonging to the group of people with disabilities unable to act within social norms. The government’s supports have been financially and reached a small number of people with mental problems (those with schizophrenia made up no larger than 10% of the total people with mental disorders in the society). In fact, the amount of financial support is not eligible for minimum living standards of the patients residing in curative health facilties. The primary focus on care for mental patients include human right protection, rights to basic healthcare, protection against abuse and discrimination have not written in any legislative and project documents. The absence of a national policy and law on mental health is the key point to explain the cause of the situation. It also leads to an uncomprehensive performance and collaboration between agencies, particularly between the LISA and the health sectors in care for mentally-ill people in Vietnam.. The treatment-based orientation of the MOH, affected by psychiatrists’ perspectives, seems to be a noticeable hindrance for the mental health system reform following WHO recommendations. The induction of the MOLISA projects (32 and 1215) is refreshing the mental health context in Vietnam as a premise for the birth of a more progressive policy and legislation to produce the reform on mental healthcare in Vietnam. The seizure of leading role in providing mental healthcare services (of the MOLISA or the MOH) will suffer the influence of the outsiders.

CHAPTER 2

Mental Health Finance State Budget

1. National budget

To date, the government budget subsidizes mental healthcare activities was transferred to the MOH and the MOLISA. The MOH coordinates payment for hospital system, the community mental healthcare program, and the project 930. The MOLISA manages budget for operations of SPCs (17 centres across the country), allowance for patients, and the project 1215. Not including budget management schemes applied in the projects 930 and 1215 which have been recently launched to target specific purposes, the funds managed by both ministries have been used according to government financial regulations. The amount of payment is estimated using designed volume of beds. Low cost norms (fees and expenditures) make the operations of these facilities nominal.

> *"We have only one source of fund from the government to cover all spending. Decrees 10 and 43 allow us to raise more funds, but which kinds of fund are available for us in the field of mental healthcare? The patients' families want to give them up, then how can we ask them to pay for the treatment? The government budget (you know already), I do not need to talk more about it. We are still staying here because of the attachment to this job for an excessive amount of time. Every capable staff has left …"* said a leader of a centre in the South of Vietnam

It is demanding for the research team to present the national data on expenses of mental healthcare. Until now, no official documents are reliable nor sufficient in reporting the amount of mental health spending paid either by each ministry (MOH and MOLISA), or by central and local levels. A ministry official explained *"…we do not know how much was spent at the local levels due to local contribution to mental healthcare activities are not required to be reported by any law. As a consequence, some provinces submitted that report, some did not do so. Poor provinces may not spend any money [on mental healthcare]…"*

To explain the grounds of the current situation of financial data reports, a ministry leader expressed *"There are several basic reasons which no official data on spending on mental health activities has been reported. First, there always has been a huge difference from the amount of draft budget to the factual provision; second, funds come from a number of sources, including "service-based revenue", international assistance, etc. and the use of these funds also experiences the same difference… it means that the true information of a facility budget is helpful for the managers, rather than for systematic management. [Thus,] there has had no demand of overall financial report…"*

Table 1: The gap between approved budget and factual provision of the MOH community mental healthcare project

Year	Approved	Factual	Difference (%)
2006	60,000	38,000	**63.0%**
2007	70,000	42,000	**60.0%**
2008	85,000	52,000	**61.0%**
2009	124,000	58,000	**46.7%**
2010	130,000	62,000	**47.7%**
Total 5 years	**469,000**	**252,000**	**53.7%**

Price unit: million VND

2. Provincial budget

The spending of local budgets for mental healthcare has experienced a similar situation. There is no expenditure statement in all official reports. It appears that the money is managed using a "particular" scheme. Notwithstanding the rules of public finance management were issued to public facilities, cost norms vary local by local, and facility to facility. This fact has disadvantages for those who are responsible for mental healthcare (Table 2). The amount of budget transferred depends on the current infrastructure of the facility (Box 8).

Table 2: Cost norms of a provincial mental healthcare facility vs. general hospital

Type of facilities	Cost norm applied at surveyed sites (million VND per bed)	Cost norm applied at reference sites (million VND per bed)
Provincial general hospital	25 (Khanh Hoa); 32 (Da Nang); 41 (Hanoi)	43 (Long An); 76 (Quang Ninh)
Provincial psychiatric hospital	23 (Khanh Hoa); 28.5 (Da Nang); 41 (Hanoi)	40 (Long An); 67 (Quang Ninh)

Box 8: Expenditure statement of Dak Lak Provincial Hospital for Psychiatrics

- The hospital was designed to include 50 beds. Currently, it is serving 51 inpatients and 378 outpatients. Human resource includes 29 personnels (6 doctors, 23 nurses);
- Funding from state budget was 2,230 million in 2008; 2,754 million in 2009. Budget for infrastructure upgrading was 3,662 million in the first half of 2010, which mainly was for equipment purchase, not for institutional operations;
- Other financial sources: (1) from the National Target Program: 620 million (2009); 66 million (first half of 2010). (2) from the service-based revenue: marginal amount, around 200-300 thousand per month, mainly from car/motorbike parking fees, and medication sale. (3) from the People's Committee donation: 500 thousand per month;
- Expenditures: 80-90% of the total budget is for salary and fringes (around 2,500 million for salary in 2010), the rest is for patients' services (foods, daily service allowance, and basic medication).

3. Budget for a mental healthcare facility: A comparison between health sector and LISA sector

Information collected helps the research team to draw an estimation of the budget for a care and treatment facility (Table 3). It should be recognized that a health facility, for example, a hospital, is advantaged by its definite title ("hospital") and the legislative lobby to allow fund raising from service-based revenue (Decree No.43). Therefore, the budget for a health facility is clearly higher than that for a mental healthcare facility managed by the MOLISA.

Table 3: State budget for mental healthcare (information collected from group discussions)

Sources of funding	Central hospital	Local hospital (provincial)	Note
1. State budget			Cost norms are varied by the levels of hospitals and if hospitals are at the same level, they are varied by the provinces
» Remuneration and regular costs (salary and patients' services)	~60 billion annual	~16 billion annual	is increasing: >50 billion in 2010, > 80 billion in 2011 (the National Hospital for Psychiatrics No.2)
» Irregular costs (repair and procurement)	~20 billion annual	~4 billion annual	will increase: additional fund from the No.930 project budget
2. Project budget (e.g. infrastructure construction using government bonds, community MH program, training projects)		~4 billion annual	will substantially climb when launching the project No.930
3. Fund raising (service-based revenue)	~8 billion annual	1 billion	
Total	**~100 billion**	**~25 billion**	**are growing when launching the new projects**

Funding for mental healthcare activities carried out by the MOLISA agencies came from a unique budget which is allocated to beneficiaries of the Decree 13. Cost norms are clarified for every type of patients living in families, in shelter homes at districts/communes, and in social protection centres, varying from the minimum of 180 thousand per person-month to the maximum of 450 thousand per patient each month. With the exception of central hospitals, the provincial hospitals for psychiatrics are limited in budget. Remuneration for staff (salary and other charges), even though from all sources of revenue, only accounts for *"a half of whom working for general hospitals"* (a manager of a health facility in Hanoi) or "*are definitely lower [than whom working for the Hanoi Hospital for Psychiatrics] at least by 1 million every month. Basic salary has gone up as required by the Decree 28*[10]*, but it is not much… some thousands extra is nothing in this economic market… the salary of our staff is not higher than non-professional labours*[11]*… the incentives of a 5-year experience nurse are not over 3 million per month"* (a staff of the social protection centre in Hanoi).

Mental healthcare activities at the local levels have not had any funding from international aids. At the central level, a major amount of outside funds are from the Atlantic Philanthropies and 95% of donated money has been spent within the INGOs who are in charge of conducting pilot models. Almost all models associated with mental healthcare run by INGOs have not finished yet (see more details in assessment report of mental healthcare models run by NGOs in Vietnam). The WHO supports workshops and meetings, and provides scholarships and (a marginal amount for) research activities which carry out by the independent institutes, for instance this study.

[10] The Decree 28/2010/ND-CP issued on 1st May 2010 decides monthly basic salary to be 730,000 VND. The Decree content is applied in May 2010.

[11] Non-professional/manual labours (wagon supporting, brick carrying and waste earth removing in constructing premises) are paid 150,000 dong per day (current cost in October 2010).

Budget distributed to specific activities has also given consideration. In a centre, 2/3 (66.5%) of total revenue is spent on remuneration (e.g. salary, fringes, bonuses), medication for patients are made up about ¼ (27.5%), the remaining is for office operations (not larger than 10%). Using this structure of expenditures, it is obvious to see that professional expectation for the quality of care and rehabilitation is hard to be satisfied. Therefore, the centre can only afford to provide housing services only, rather than care giving and rehabilitation for the clients.

The community mental healthcare managed by the MOH spent a considerable amount on IEC (10%) and training (20%), and the rest is for professional activities with a large portion for medication (70%).

Table 4: Structure of expenditures in mental healthcare

Sector	Total annual income (thousand VND)	Annual expenditures (thousand VND - %)		
Social protection centre[a]	23,120,340	Remuneration (salary, fringes, bonus)	Medication	Office operations
		15,146,052-65.5%	6,358,130 27.5%	1,616,148 7%
Community mental health project[b]	58,642,000	IEC	Training	Medication
		5,940,000 10%	11,880,000 20%	40,822,000 70%

[a] *According to financial report in the first six months of 2010 of a centre in the North. Numbers are rounded up to thousands VND. Cost items follow reported classification;*

[b] *Data are withdrawn from 2011 budget allocation plan of the project, reported by the MOH representative at the Workshop on the National Target Programs for NCD prevention. The workshop was organized by the NA Committee for Social Affairs in 8th March 2011. The table shows parts of budget distributed to provinces, not including central budget (11,358 million VND).*

In conclusion, the state budget completely controls the funding for mental healthcare in Vietnam. However, it is hard to give a specific indicator regarding budget paid for mental healthcare per capita, because the inavailability of data reported by the two key minitries (MOLISA and MOH). In case of data available, they were not sufficient and their reliability is possibly questioned. During the last five years, budget for mental health has significantly risen, approximately 13% per annual in average for regular expenditures, and about 53% for the community project. Furthermore, local contribution also was considered and it varied by provinces. Other sources of funding were not available. State budget was affordable just for the very basic curative services using medication. The budget for the community project swiftly increases, also in the field of medication supplies (70%). That for social protection centres coordinated by the MOLISA has comparable features to health facilities; however that for the community social protection has directly delivered to the patients. Allowance for in-charge community LISA staff to do social protection supports is not paid separately, because the work is considered to be of their functions, that is to provide supports for vulnerable targets in the society.

CHAPTER 3

System of the Social Protection Centres managed by MOLISA

1. Roles and coverage

Throughout 63 provinces of the country, 16 provinces have social protection centres to provide menal healthcare treatment and services for people with severe and chronic illnesses (Box 9). HCMC has two centres, bringing about a total of 17 centres in Vietnam.

Box 9: List of 17 social protection centres for mental patients

1. Viet Tri mental health nursing and rehabilitation centre (Phu Tho province);
2. Son La mental health nursing and rehabilitation centre;
3. Thai Nguyen mental health nursing and rehabilitation centre;
4. Hanoi mental health nursing station
5. Hai Phong city mental health nursing and rehabilitation centre;
6. Hai Duong mental health nursing centre;
7. Hung Yen mental health nursing station
8. Thai Binh mental health nursing centre;
9. Ninh Binh mental health nursing and rehabilitation centre;
10. Nghe An nursing station for invalids with mental and neurological illnesses
11. Da Nang nursing centre for people with mental diseases;
12. Quang Nam housing centre for people with mental diseases;
13. Hoa Nhon mental health centre (Binh Dinh province);
14. 2 HCMC nursing centres for people with mental diseases;
15. Ben Tre mental health nursing centre;
16. Ca Mau nursing centre for people with mental diseases;

The social protection centres operated by the MOLISA are responsible for providing treatment and rehabilitation to people with mental illnesses, who are also invalids, among elderly, poor persons, and orphans. These targets are beneficiary of social support policies[12]. This function clearly differs than that of psychiatric hospitals or psychiatric departments of the provincial general hospitals (Box 10).

[12] According to the Decree 67, social protection beneficiaries include: (1) Orphans, children who are abandoned or have nobody to rely on; (2) Lonely elderly people in poor households; elderly people in poor households (according to the poverty line stipulated by the Government in each period) whose spouse is old and weak and who have no child, grandchild, or relative to rely on; (3) People aged 85 or older who have no pension or social insurance allowance; (4) Seriously disabled persons in poor households who have no working or self-serving capacity; (5) Mental disease patients suffering from schizophrenia or mental disorder who have been treated for many times by psychiatry institutions but shown no sign of recovery and filed chronic disease records, live alone without any support or are members of poor households; (6) HIV/AIDS-infected persons in poor households who have lost their working capacity; (7) Families and individuals adopting orphans or abandoned children; (8) Households having two or more seriously disabled persons who have no self-serving capacity; and (9) Single persons under the poor household category who are raising child(ren) under 16 years of age.

Box 10: Roles and responsibilities of three provincial facilities related to mental healthcare

The psychiatric hospital or the psychiatric department of the provincial general hospital (managed by the DOH):

- Outpatient services
- Providing treatment for acute and chronic cases (maximum 3-month inpatient)
- Participating the council for civils' mental status diagnosis (speciafically, that for criminals' has to be organized in the regional hospitals, as required by the Decree 03)

The psychiatric department of the centre for social disease prevention (managed by the DOH):

- Community network and medication delivery supervision
- Public awareness education

Mental health nursing and rehabilitation centre (managed by the DOLISA):

- Providing treatment and rehabilitation to mental people, including invalids, lonely elderly, poor households, and orphans, who are beneficiary of social support policies.

2. Services

Five mental health nursing centres in Hanoi, Son La, Da Nang, Ben Tre and Binh Dinh are delivering inpatient services to mentally-ill clients, concentrating on rehabilitation, medical treatment and physical therapy. Most patients were enrolled in physical therapy in various levels of duties. Psychotherapy, particularly group therapy, is not usually used due to human shortage.

With the exception of Hanoi and Da Nang centres where beds are not fully loaded, the others are in the status of fully occupied (Binh Dinh and Dak Lak) or overloading (Son La). In comparison to the community demands, the serving capacity of the centres can only provide a small percentage of the real needs as evidenced by the statistics inSon La province (Box 11).

Box 11: Statistics of mental healthcare in Son La province

Total patients: 1,488

- Number of poor patients: 807 persons
- Patients have never been examined: 618 persons
- Patients have not received any financial support: 764 persons
- Number of beds as designed: 60 beds
- Patients are living in the MOLISA centre: 78 persons
- Patients whose families is submitting proposals to send them to the centre: 159 persons (excluding 78 enrolled clients)
- Patients have been delivered medications within the community mental healthcare program: 695 persons

Source: Statistical report of DOLISA Son La, 2010

3. Infrastructure

According to the Decree 68, social protection centres must meet the following physical environment:

- Ward space: approximately 30 m^2 per user in rural area and 10 m^2 per patient in urban area
- Indoor space: 6m^2 per patient, for patient who needs 24/24 hour follow-up, it is about 8 m^2 per bed. This space is equipped neccesary utensils for daily services of the patients.
- Social protection facilities nursing over 25 patients is required to have indoor space, kitchen, staff office, recretional space, water supply, power system, communal roads, manufacturing and working area for working therapy (if possible)
- Social protection facilities nursing 10 to 25 patients is required to ensure basic housing, kitchen, staff office, water supply, power system.
- Local usage and equipment should be accesible and comfortable for the disabled, the elderly and the children.

In reality, the infrastructure of the mental rehabilitation centres has not satisfied all the required criteria of the Decree no. 68. The campus is large and clean, has playgrounds and has two separate areas (one is for patients with mild problems, and the other is for the severe ill). However, indoor space 6 m^2 per patient is not reasonable. In normal circumstances, 4 patients are loaded in a 12m^2-space and a 30m^2-space is loaded with 10 beds. The living condition is poor with danky space, inadequate ventilation, and no in-house water heating system for bathing in winter. Among eight visited provinces, Da Nang centre was best equipped due to having aids from the internationally-funded projects and the financial supports of the provincial People's Committee. In general, the infrastructure of the surveyed centres have not been designed, operated and run in accordance to operational principles of a standard one for mental healthcare and rehabilitation, of which the patient-based approach is applied and fundamental human rights are respected.

In reality, the infrastructure of the mental rehabilitation centres has not satisfied all the required criteria of the Decree No.68.

4. Personnel, recruitment mechanism and training

The Decree 68 regulates the number of staff responsbile for providing care for mental patients living in the social protection centres:

- For patients with severe problems (having violent actions, last-phase dementia): 2 patients per staff;
- For patients with signs of improvement: 3-4 patients per staff;
- For recovered patients: 8-10 patients per staff.

Some directors confirms that these criteria are challenging to be met in Vietnam . To care for a severe mental patients, a staff is in charge of serving four to five patients, while the facility is temporarily short of staff due to annual leave or training attendance, the burden of care for patients may be larger (six to seven patients per staff). With inadequate personnels, it is difficult for the centres to recruit doctors and nurses because they do not want to involve in mental health sector with high workload and low incentives.

"Annually, we nominate 3 or 4 staff to attend invited workshops. In 2007 and backward, we had received invitations sent by the MOH to participate in professional training courses. When the MOH recognized that our centre is being managed by the MOLISA, they have not sent us any invitations. In 2010, there was only 1 person who attended a short course. We have never been visited by or worked with any international delegation" (Son La mental rehabilitation centre)

As reported by informants in the eight settings, staffs working for a mental rehabilitation centre do not have many opportunities available for either short course or long-term training to improve their profession and qualifications.

5. Monitoring and quality controlfor patients' rights

The centres have introduced internal supervision conducted by the board of directors and heads of departments. The DOLISA inspection happens once per year, focused on financial management, political direction, and no performance supervision. Vertical supervision system from the highest level to provincial level has not been established. No independent monitoring on quality control and human rights is applied. All of the surveyed facilities had not been supplied with any technical guidelines and lacked communication and professional collaboration with other peers within the system or with other relevant systems, particularly that of the MOH.

A common problem of all social protection centres is a lack of training materials for curative treatment and rehabilitation for the mentally-ill people. In particular, non-pharmaceutical approaches in mental health have not officially introduced in treatment procedures of the centres. Some have applied physical therapy (e.g., cow breeding, vegetable planting in Son La centre, cleaning and food delievering in Hanoi centre), but scientific principles behind the use of these therapy is not well understood by the providers. Training activities to improve service quality should prioritize basic training on non-pharmaceutical treatment and rehabilitation methodologies, which are recommended to be entirely integrated into professional care procedures towards patients.

No independent monitoring on quality control and human rights is applied.

Assessment of Community Social Protection Workforce

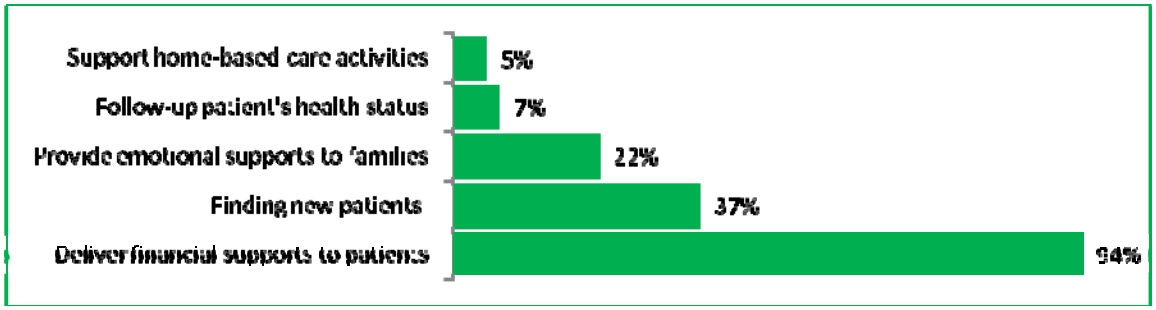
CHAPTER 4

1. Social protection officers' work towards mental patients

There is no specialized staff who was assigned by the district DOLISA to be in charge of following-up with the mentally ill. Four employees of the district DOLISA are responsible for all duties in association with social protection. Their jobs involve provision of supports to the poor, contributors to the Revolution, orphans, homeless people, abandoned elderly, people with mental illnesses, the disabled, people living with HIV/AIDS, and people who are in endanger situations (abandoned children, victims of domestic violence, sexual abuse, trafficking and labour abuse). On average, a social protection worker spends seven days every month to deal with tasks connected to people with mental problems (5.3 days minimum to 9.6 days maximum). An estimated 94% of the officers have spent these seven days solving administrative procedures linking with supports for the sufferers, and 37% reported that they have also given efforts to find new patients.

54 social protection workers of the district and communal DOLISA were interviewed to assess the community mental healthcare providers, using quantitative questionnaire – Form C2. The form consists of 24 questions to collect information on their duties, materials and equipment, knowledge and skills eligible to a community social protection and mental healthcare provider. Chapter 4 summarizes the findings.

Figure 1: Social protection activities for people with mental illnesses (n =54)



2. Professional training

"Tasks are appointed to us without any tools. When we are in trouble, we do not know what to do, and who to call for help?" - A communal social protection officer, in Hat Lot district

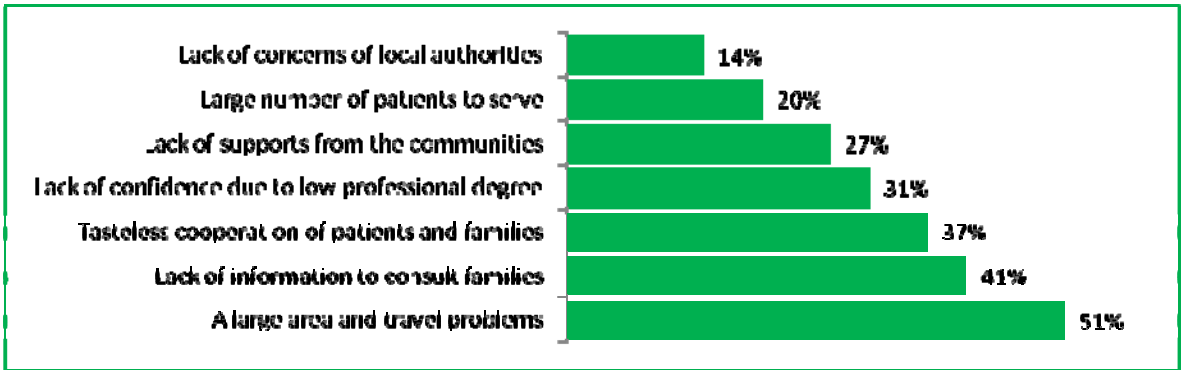
[Refer to a patient being locked in a cage] "That [mental] person is pitiful, but I do not know how to help" - A communal social protection officer, in Thuan Chau district

When being asked *"Have you ever participated in any training course on social protection or mental healthcare?",* 76% out of the total respondents reported positively. Training courses usually provided policy guidelines on the delivery of social supports to the beneficiaries. Training on professional knowledge and skills of early detection, standard operational procedures, and stimulation of participation of related agencies to urgent cases (such as person who violently disturbs others, abandoned and abused persons) is totally absent.

3. Difficulties of the social protection staff

An estimated 89% (36/54) informants revealed that they have difficulties performing their duties With alarge area regarding transportationas the biggest challenge to the work of 51% of the surveyed people. Their second difficulty is the lack of information to consult patients and families which 41% have reported. The following ones include the lack of cooperation from families and communities, and lack of confidence due to low professional degree.

Figure 2: Difficulties experienced by social protection workers



Box 12: Criteria of a good social worker and supportive environment to work

- Being interested in social work;
- Being trained with counselling skills and being equipped with materials;
- Being provided proper incentives: to be employed long-term, to have health and social insurance, to be paid per diem when is on business visit to commune area.
- Being provided operational procedures, clear responsibilities of collaborative partners are identified;
- Having technical agencies for referral of patients who were recognized by social protection workers.

Group discussion with 6 communal social protection workers

Community Needs on Mental Healthcare

CHAPTER 5

1. National mental health burden

Epidemiological studies on ten common mental disorders in the settings of eight socioeconomic regions of Vietnam during three years (2000-02) informed that 14.9% of the population had mental disorders [9]. A 2003 MOH-UNICEF joint research in youths aged 14-25 notified that 32% of young persons felt boring with their lives, 25% experienced hopeless and lost their appetite with everything in life, 21% got very upset over their future, 0.5% committed suicide and 2.8% ever did self-harm [10]. Another study in Hanoi in 2005 conveyed that people having suicidal attempts occupied 8.9% in the community, 1.1% planned their suicide and 0.4% effectuated their suicidal plans [11]. Jane Fisher et al reported that 33% women who used healthcare services in a HCMC facility was depressed and 19% experienced thoughts of suicide [12]. Young Lives Vietnam Country Report illustrated mental disorders were being suffered by 20% children in the age of eight and 20% women having babies under one year old. Subsequently, the data were disseminated in the workshop on childhood poverty organized by the NA Committee for Social Affairs on September 2004 [13].

A WHO multinational large-scale study briefed that people with mental disorders accounted for 25 - 30% of population in developing countries. Of those, 20% are psychotic disorders, and the rest belongs to neurotic disorders, for example depression, anxiety, stress-related disorders, behavioral disorders, disorders due to alcohol and sustance abuse. The MOH estimated that with such ten common mental disorders, Vietnam has no less than 12 million people who need mental healthcare[13].

MOH estimated that with such ten common mental disorders, Vietnam has no less than 12 million people who need mental healthcare

Table 5: Mental health prevalence in some countries [3]

Mental disorders	US	UK	China	Taiwan	Korea	Vietnam
Schizophrenia	0.6-1.1%	0.68-1.3%	0.42-0.47%	0.31%	0.31-0.54%	0.47%
Epilepsy	0.3-0.5%	0.46-0.62%	0.3-0.5%	0.43%	0.26-0.47%	0.33%
Depression	3-5%	2.8-4.2%	2.3-4.5%	3.6%	3.1-5.3%	2.8%
Mental retardation	0.5-0.7%	0.42-0.61%	0.38-0.57%	0.55%	0.38-0.57%	0.63%

[13] The NA Committee for Social Affairs (2011). *The MOH's report to The NA Committee for Social Affairs regarding the suggestion on the national target program* (including community mental healthcare project); Hanoi, 8/3/2011.

2. Coverage of mental healthcare network

In Vietnam, there are 19 beds for mental healthcare every 100,000 people provided by two systems of the MOH and the MOLISA. The MOH system provides 12.2 beds out of 100,000 people. This ratio is considerably lower on par with other nations in the world.

Mental disorders which are being targeted in Vietnam are schizophrenia, epilepsy and severe forms. The disorders which engaged a high rate of sufferers and are treatable including depression, anxiety, sleep problems, alcohol abuse which is currently made of 80% community mental health burdens are not the main focus of the community mental healthcare program. Mental healthcare services for pregnant women, young children and adolescents are not available and accessible at grassroots level [4].

Table 6: Beds for mental healthcare ratio: a comparison to some countries [3]

Countries	France	Russia	Sweden	Germany	Poland	Netherlands	Vietnam
Beds per 100.000 people	165	125	85	60	57	50	12,2

3. Mental healthcare needs at the provinces

A household survey was one of the study components, applying a quantitative semi-structure questionnaire and a patient questionnaire which comprises 27 questions to gather data on the diagnosis of patients' illness, treatment processes, current status of the patients, health costs, families' needs, information accessibility, problems facing the families during examination and treatment processes, and at home-based care delivery, as well as comments of patients' families for social protection activities for patients. The interviewees mainly were the chief caregivers, mostly the parents and the siblings of the patients. In summary, 244 households were randomly selected to participant in the survey.

> 18.8% of the surveyed families disclosed that they sometimes had to use violence (imprisoning, roping, fettering) to control the patients.

3.1. Patients' state

An estimated 48.7% of the mentally ill is incapable for self-care and totally depend on their families; 18.8% of the surveyed families disclosed that they sometimes had to use violence (imprisoning, roping, fettering) to control the patients. To be asked *whether the family has anyone who purposely care for the patient*, up to 11% asserted that their families could not arrange any special person to provide care for the

patients. They also expressed a common wish to send the patients to the MOLISA centres.

Table 7: Capacity of doing housework and self-care (N=241)

	Usually	Sometimes	Never
Capable to do paid works	1.7%	1.2%	97.1%
Capable to do housework	14.1%	24.5%	61.4%
Capable to do self-care	35.0%	16.3%	48.7%
Being frequently cared and controlled by another	50.6%	22.6%	26.8%
Being controlled by violent measures (imprisoning, roping, fettering)	18.8%	0%	84.2%

** 3 missing values*

The data shows 85.1% (206/242) of the investigated patients were taking medications for treatment. Of those people, 79% (136/206) was delivered free medications. With regard to 21% (43/206) of patients whose families have to pay out-of-pocket money for medication, their family spent averagely 300 thousand VND every month to buy medicines (95% CI: 277 – 377 thousand VND). This amount was sometimes unaffordable for rural households. Out of 244 surveyed families, 97% was ranked as poor (56% as very poor and 41% as poor) following income classification criteria applied in the local. Amongst interviewed households, only 3% was better-off or wealthy.

3.2. Families' needs for better care for mental patients

Generally, the families are not knowledgeable to the guidelines on home-based care for the mentally-ill relatives. Homecare is provided in their own ways.

"My husband's sibling has been diagnosed with schizophrenia for over 30 years. We have not had any doctor's home counselling. Many people do not know that my family has a "neurotic-disordered" member. Whenever we hear about a similar case, we try to chat with them to learn lessons." - A patient's sister-in-law in Mai Son district

"He is confined at home. He threatens to hit and beat everything if we do not allow him to go outside. Then we have to let him hang around for a short while. He does not do any housework. I always need to clean the toilet after his use. He has a 34-year-old younger brother that does not want to get married because of the threats which are possibly caused by his brother. There are no organization where I can ask for help. He is my child, so that it is my obligation to look after him. I wish to send him to a institution house." - A patient' mother in Quyet Thang commune

"We are always in stress. We sometimes wish that he died int a car accident.. We can not wait for government supports anymore. We have been told about a mental healthcare centre by our neighbours. But there have been no patients in this area that hasenteredg that centre in the recent years. The family members are the mostunhappy ones" - A patient's older brother in Hat Lot town

"*It would be helpful if positive examples of good homecare can be shared to families having mentally ill members. Thus we may be able to provide better homecare for my relative. Staff of the commune health centre visited twice in 2010 to instruct frequent medicine in-take. They did not give us any more guidelines."* - A patient's younger brother in Quyet Thang commune

Quantitative survey in 244 households indicates that 63% of households replied that their mental relatives have been given free health examination and treatment services and 54% of them are being supported financially by the local authorities (monthly payment as required by the Decree 13). Only one third (32%) of responded families received home-based counselling (Figure 3).

Some families commented that commune health staff visited their homes for a purpose of handing over medicines and of examining the present state of the patients. They also encouraged family members emotionally in a general sense, but rarely provided counselling or instruction of home-based care methods. Social protection workers came only to collect information to fill up forms for administrative procedures to obtaining government supports.

When asked "*What do you expect to be supported for a better care for the patient?*"[14], 45% desired psychological counsellig services for patients and family members, 36% asked for information associated with mental illnesses and 27% wanted specific guidelines on home-based care (Figure 4).

Interviewed families also expected to be provided with instructions, experience and direct counselling from community collaborators (Figure 5). It expounds that the community mental healthcare system should be developed following ten WHO recommendations, where the 4th advice (Educate the public) may be introduced in the form of extended community training programs and the 5th one (Involve communities, families and consumers) will be in the style of of home-based care models which are established based on types of illnesses and household economics.

Figure 3: Community supports for families (n=242)

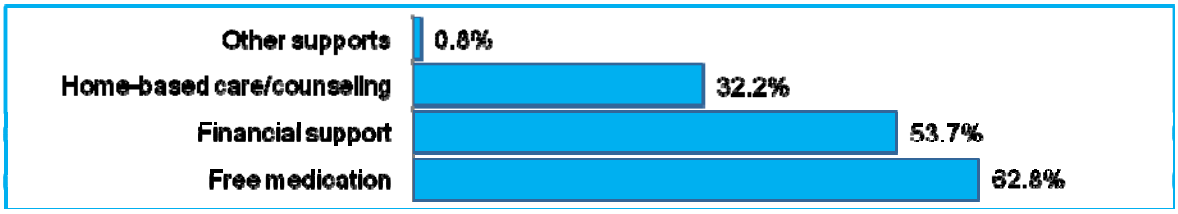
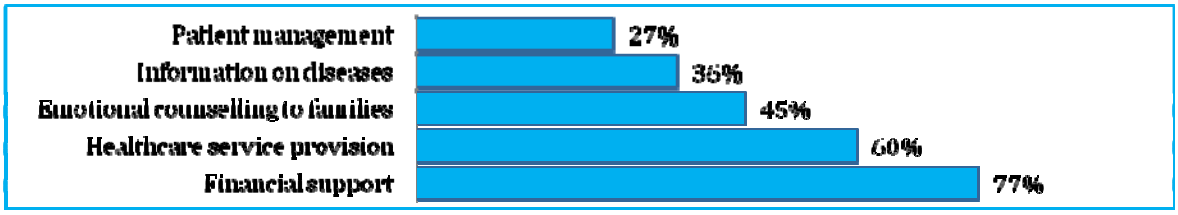
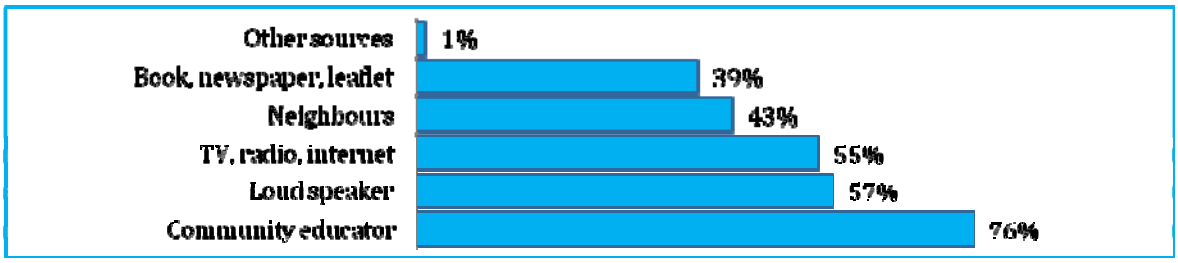


Figure 4: Expected community supports (n=242)



[14] The respondents reported their wishes without any helps from the interviewers. The interviewers recorded answers, then coded options themselves. The data collectors did not probe by reading loudly probable answer options

Figure 5: Expected sources of information on patients' care (n=212)



Box 13: 10 WHO recommendations on mental healthcare

1. Provide treatment in primary care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national policies, programmes and legislation
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support more research

Policy Recommendations and Implications

CHAPTER 6

The research evidence, analysis and interpretation reveal that Vietnam is on the right track to change the national mental healthcare system.

Overall, positive movement towards mental healthcare has been noteworthy with the active engagement of the CP, the NA and the independent organizations during the last five years. The increase of state budget provided to the system operations and the MOH's and MOLISA's facilities which involved in mental healthcare is a profound example. The quality of social supports for vulnerable groups in general and for the mentally ill in particular has improved and the support activities were delivered in the same purpose for the equity in social welfare provision.

The continous launching of three national projects (930, 32 and 1215) during the last three years has directly affected mental healthcare activities in Vietnam, they seem to make us in a confusion. The dynamic investment in these projects made by the Government is stimulating a significant growth of human resources working for the sake of an achievement of project goals, at both macro and micro levels. However, it can be foreseen that the implementation of the three projects, coordinated by the MOLISA and the MOH, is potentially resulted in two different movements on the mental health system of Vietnam. While the project 930 promotes the hospital-based treatment, the projects 32 and particularly 1215 encourage the community-based care following WHO recommendations. In these two projects, curative facilities play the role of supportive care. Clearly, both components are necessary in the mental health system in Vietnam, including curative facilities (psychiatric hospitals managed by the MOH, especially at provincial level and social protection centres run by the MOLISA) and preventative medicine (responsible for prevention, early recognition, early treatment and community-based care and rehabilitation).

In that context, there is a need of a strong orientation effort that could drive projects towards harmonization, no overlap, feasibility to the current mental health system and affordability to Vietnam.

It is a national policy on mental health. Magnetizing the participation of domestic resources and call for strong support from the international community, particularly from the WHO in order to facilitate the birth of a better mental health policy is inevitable. These measurements aim to guide Vietnam in the proper direction to the development of strategies in national mental healthcare field.

To backup the improvement of the quality of mental healthcare in Vietnam in the coming years, the study team suggests five conclusions, and five recommendations for actions for the period of 2012-2013, where one is particularly directed to the WHO and to the UNICEF.

Conclusions

1. The mental healthcare system managed by the MOLISA consists of seventeen social protection centers in sixteen provinces. It is responsible for making national social protection policies that affect vulnerable populations, including mentally ill patients, in every commune in Vietnam. This system functions parallel to a MOH system which includes the National Institute of Mental Health, two national psychiatric hospitals, 32 provincial psychiatric hospitals, 33 psychiatric departments at provincial general hospitals and 33 psychiatric departments at provincial social disease centers, in addition to a national community-based mental healthcare program that is now functioning in 70% of the communes. The core activity of this program is the distribution of medication to identified schizophrenics and epileptics (diagnosed at either a provincial or a national psychiatric hospital) by communal healthcare centers.

2. There is a lack of a comprehensive mental healthcare national policy. This has resulted in a winding interaction between the MOLISA and the MOH systems, as can be seen in the national standard guideline package and the practical performance at the local level. Projects 32 and 1215 have created a context which invites collaboration amongst various agencies, particularly MOLISA and the MOH.

3. The mental healthcare system managed by MOLISA has the following noticeable features:

    a. The social protection and rehabilitation center for mental patients has acted as a physical institution which takes in patients who live in the street, who were ignored by their family members and relatives, who have no caretakers or who are members of a family that was recognized for its involvement in the struggle for the Independence of Vietnam. The centers exist in only sixteen provinces/cities (approximately 20% of provinces in Vietnam). At present, these centers can provide less than one third of the mental healthcare needs of those residing within those provinces/cities. In the eight surveyed settings, it was discovered that the services that were jointly provided by MOLISA and the MOH has been devoid of professional standards. The network that has been established has provided nothing more then administrative and logistic management which includes referral and the discharge of patients. This situation may exist because of the lack of a regulation of professional activity and standards by the provincial healthcare system. It was found that 18.8% of the mentally ill patients surveyed are at present caged and or fettered at home because their families and communities, who would like to send them to the social protection centers, had their application requests denied.

    b. While healthcare goals have been set by the Vietnam Communist Party (CP) and WHO has made healthcare and rehabilitation recommendations for people who suffer from mental health problems in developing countries in these early decades of the 21st century, the MOLISA system lacks even the basic resources that could meet the mental healthcare needs at either institutions or communities. All seventeen of the provincial centers face a severe shortage of necessary resources. While the human resources are enthusiastic about carry out their duties, they have not been professionally trained and they have not acquired information or skills needed or learned methodologies and they are unable to provide proper healthcare and rehabilitation for those who are mentally ill. The physical environment has not been designed or equipped to function as a mental healthcare rehabilitation facility and it therefore is not operated as such and cannot provide a patient-centered approach which respect their fundamental human rights. None of the surveyed facilities had been supplied with any technical guidelines and none of them were in communication or collaborating with their peers within the mental healthcare system or any other relevant system, and this was particularly the case regarding the MOH. Significantly, their budgets were so limited that they could provide housing services only and not mental health care or rehabilitation of the clients.

c. For the last five years, the MOLISA system has delivered social protection services as required by Decrees 67/2007/ND-CP issued on April 13, 2007 and 13/2010/ND-CP issued on February 27, 2010. These decrees include the provision of services to the mentally ill patients. By 2011, it was assessed that the system provides the basic services required by Decree 13 to mentally ill patients. However, according to the MOLISA's definition:, "a mentally ill person" is anyone who was treated at a psychiatric hospital. So, anyone who did not receive treatment at a psychiatric hospital is by definition 'not mentally ill'. Consequently, many people who are mentally ill are not a statistic of the MOH system and activities managed by the MOLISA ignore a large proportion of mentally ill people who need assistance.

d. It can be seen that the mental healthcare systems operated by either MOLISA or the MOH have given attention to psychotic disorders but it ignores such things as depression, anxiety, post traumatic stress disorder, disorders due to alcohol abuse or substance abuse, and particularly those mental disorders which are common in pregnant women, breastfeeding mothers, children and adolescents. Such care is not being provided for a number of reasons, the main one being the lack of an IEC program to provide basic information of staff members and citizens on the prevention, treatment and rehabilitation of mentally ill people.

4. There exists a plan to upgrade the system by implementing two national projects, one being "National Project 32/QD-TTg in reference to the development of social work," issued on March 25, 2010, and the other being "National Project 1215/QD-TTg in reference to community-based social support and rehabilitation for mentally ill patients and people with mental disorders period 2011-2020," issued on July 22, 2011. The possibility that these projects might be realized is a positive movement by MOLISA and it reflects a strong political determination of the Vietnamese government in the last two years to improve social equity and security in general and for the benefit of the mentally ill people in particular.

5. Due to a severe deficit of resources and cooperation between agencies and two new Projects 32 and 1215 (they are both still in the model establishment phase), there has been no substantial improvement in the provision of mental healthcare since late 2010 when the research team collected the data. It is also obvious that the training bodies of MOLISA, the MOH and the Ministry of Education and Training are now even less able to provide on-the-job training to fill the gaps in profession within the MOLISA system at both community and provincial levels. Therefore, it is believed that the conclusions and recommendations that resulted from this study are pertinent and offer a good opportunity for MOLISA to adjust its priorities and schedule the implementation of Projects 32 and 1215 in the next two years (2012-13).

1. Establishing a vision and national action framework for mental healthcare in Vietnam should be given priority status in these next two years. Plans should be made to carry out the activities presented in Projects 32, Project 1215, the mental healthcare project within the National Target Program and Project 930/QD-TTg of June 30, 2009 (which addresses improving and establishing provincial psychiatric hospitals where that kind of hospital does not yet exist), to be run by MOLISA and the MOH. A taskforce group should be created to draw up the draft and introduce a national mental healthcare policy that can function with the existing resources of the nation and approximate WHO recommendations. The policy should facilitate the collaboration of ministries and local agencies to result in the creation of action plans that could function between now and 2020, with a goal being the forming an integrated multi-sectoral mental healthcare system of which the core component is preventative medicine, rehabilitation and community-based support activities for mentally ill people.

2. The National Assembly (NA) is encouraged to issue a resolution to extend the political imperative for MOLISA and the MOH to get together to build and implement one system of community-based mental healthcare at the grassroots level. Meanwhile, it is suggested that MOLISA's Projects 32 and 1215, the national target programs and MOH's Project 930 focus on an overall objective that would renovate the mental healthcare and rehabilitation system for the mentally ill people following WHO recommendations and with a goal of "equity, efficiency, and sustainability" in healthcare as set by the CP. If this direction is taken, each project would concentrate on specific objectives to form both an infrastructure and a management mechanism of the mental healthcare system in every province. These systems would function with the treatment and rehabilitation facilities and the community-based care regime.

3. Activities on mental healthcare in 2012 should be scheduled as follows:

    - To obtain agreement on the vision and action plan framework for the national mental healthcare policy. This is a high priority activity and every effort should be made to attract the participation of various organizations and multi-sector researchers.

    - To design a mental healthcare model that can function at the provincial level based on the strategies presented in Projects 32, 1215 and 930 and the national community-based mental healthcare program, as well as WHO recommendations. This model is to contain two components: (1) **A basic, community-based component** which is responsible for preventative medicine, early detection, early intervention and treatment and early rehabilitation. It is to be performed and controlled by a multi-sectoral workforce made up of social workers and health workers; (2) **A support component** consisting of care and treatment clinics which involves the cooperation of the psychiatric hospitals with consideration for social protection for mentally ill patients. There should be one clinic in each province that can diagnose, treat, care for and rehabilitate severe psychiatric cases.

    - To plan and introduce an integrated mental healthcare model at the primary level (district or commune), piloted in one district.

4. It is suggested that a technical support group be established containing national experts with experience in multi-sectoral consultancy or those who specialize in mental healthcare, to link and backup the activities run by MOLISA and the MOH. This think tank should be formed and coordinated by VUSTA because its role as assigned by the NA and the Vietnamese government is to provide technical consultancy and critical review for the development of programs and projects.

5. The support of UNICEF and WHO is indispensable and this should be promoted using three approaches:

- Help relevant ministries to agree on a holistic and community-based approach in mental healthcare and to give priority to models and initiatives which are based on research evidence and are appropriate when considering the existing resources of the country.
- Foster the establishment and operation of the technical support group while also advocating for the swift creation of political and legislative framework on mental healthcare in Vietnam. Workshops and pilot studies to collect evidence for policy-orientation should be endorsed in 2012-13.
- Provide consultancy to VUSTA to help them establish and run mental healthcare think tank and ensure its role as a scientific and independent voice that will influence policy review of relevant law makers (the NA Committee for Social Affairs, the Department of Social Affairs of the Commission for Ideology of Communist Party, MOLISA, MOH and Ministry of Finance).
- Strengthen the involvement of civil society organizations in the area of mental healthcare by providing them with technical and financial aid so that they can establish and pilot policy-oriented models, fund workshops and engage in policy advocacy activities making use of evidence obtained in field studies and human resource training.

No Health is without Mental Health

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Annex 1: Informants in eight provinces

No.	Province	A1	B1a	B1b	B2	B3a	B3b	B4	C1	C2	C3
1	**Hanoi**	3	3	15	12	1	1	2	6	18	31
2	**Son La**	13	6	5	12	3	1	1	9	10	31
3	**Ben Tre**	8	3	12	7	3	1	2	9	20	30
4	**Kien Giang**	6	2	8	4	2	1	1	10	23	30
5	**Đak Lak**	7	1	9	6	2	1	1	8	21	32
6	**Da Nang**	9	2	6	5	1	1	2	9	21	30
7	**Quang Ngai**	10	2	8	4	1	1	1	10	12	30
8	**Binh Dinh**	12	3	5	6	2	2	2	8	12	30
	Total	**68**	**22**	**68**	**56**	**15**	**9**	**12**	**69**	**137**	**244**

A1 = for leaders of central offices, DOLISA, DOH, psychiatric hospitals/facilities, district DOLISA, district DOH	B1a = for leaders/specialized staff of social protection centres; 05/06 centres; provincial hospitals for psychiatrics/psychiatric departments in general hospital	B1b = for practictioners/officers directly provide services to patients (doctors, nurses, technicians, olderlies, admin staff)
B2 = Household questionnaire (qualitative interview)	B3a = Data sheet of social protection centres and 05/06 centres (self-administered by statisticians)	B3b = Data sheet of provincial hospitals for psychiatrics/psychiatric departments in general hospitals
B4 = Observation checklist of mental healthcare facilities	C1 = Qualitative questionnaire for social protection officers	C2= Quantitative questionnaire for social protection officers and health workers
		C3 = Quantitative questionnaire for households having mentally-ill health members

Annex 2: Evaluation of community mental health project managed by MOH: A report summary

COMMUNITY MENTAL HEALTH PROJECT IN HA NAM AND HA TAY
A cost-effectiveness analysis

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The research aims to provide a cost-benefit analysis on the community mental health care model using various information sources, including secondary data from the health routine information system and primary data collected through interviews with project designers, managers and implementators at central and local levels and with patients, families and commune health workers in nine selected communes in the two provinces of Ha Nam and Ha Tay. These selected communes represent three groups: communes with the best implementation of the model (3 communes), communes with moderate implementation (3 communes), and communes that have not implemented the model (3 communes).

In total, 19 in-depth interviews were conducted with key mental health professionals at the national, provincial, and communal levels. The interviews examined model inputs, activities, outputs and outcomes at the communal level. In addition, a survey was conducted with a sample of 199 patients (190 schizophrenia and 90 epilepsy patients) and their families to measure patterns of mental health care seeking behavior, costs of care, and benefits gained from the consumer perspective. Both commune health workers and patients/families were interviewed on their knowledge of mental health issues and suggestions for improving mental health care at the communal level. The model was analyzed under the WHO framework for community-based mental health care in developing countries, the Vietnam health policy 2000-2010, the Logical Framrework Analysis tool for evaluating a community intervention on health care, and the cost-benefit analysis tool for evaluating a community intervention model.

The study found that:

1- The model has the following key features:

- The model was developed for the management of schizophrenia and epilepsy and was based on the approach of distributing drugs for treatment of these diseases at the communal level through the commune health centre (CHC) and village health worker network. This project is a continuation of the 1976 plan on management and provision of free medication to schizophrenia and epilepsy patients. To date, the project funding has been supported by state and local budgets. International aids and national donation are unavailable

- The current project vision and approach basically follow WHO recommendations on community mental health care in developing countries, but the project scope is limited to the management ofschizophrenia and epilepsy. Other neurotic syndromes such as anxiety, depression, obsessions, acohol abuse, sleep problems, and unexplained somatic problems are not included in the community mental health care project.

- The current project approach is totally dependent on the capacity of hospital staff who conducted household surveys for identifying patients with psychosis. In all of the studied communes, this worked well at the time of introducing the project to communes, but post-evaluation annually is rarely conducted. Therefore, this approach is not sustainable and is costly, compared with the approach of educating the public to use psychometric tools for screening of mental disorders, following which probable cases are sent to hospitals or mental health clinics for confirmation and treatment.

2- In implementation of the model, almost all communes received poor inputs and medication distribution and management is the dominant activity. Other activities (training, material development, baseline survey) are conducted by central team.

- Model implementation training at communal level is only for schizophrenia, and is directed at health staff only. Distribution of training and education materials is limited among the health professionals and there is little action conducted at the communal level to educate the targeted community groups on mental health care;

- The training program is not designed professionally; there are limited training documents, and there is not enough focus on building skills and practice in mental health care at the community level, especially in psychotherapy, rehabilitation and environmental change for patient care.

- Budget provided to communal health centre is small without any monitoring scheme which is applied to control the transfer of required amount of payment to the recipients: 20 thousand per village health collaborators, 5 thousand per patient to rehabilitate;

3- Model project management, support and supervision

- Project data reported that patient management at CHCs seems reliable in Ha Nam, but was more questionable in Ha Tay. In Ha Tay, a big gap between the number of custumers having patient files managed by the CHCs and the number of patients collected by field survey by the research team.

- Inspection and supervision were mainly focused on medication delivery and varied by districts and provinces. The distribution of inputs which was calculated based on the number of patients may result in the reporting of a higher number of cases than there actually are in Ha Tay.

- No official data of project inputs for the implementation in communes was reported. Annual financial data was collected from expenditure statement reports administered by the provinces and the central coordinator. However, the difference of reported data with factual costs and costs data collected from interviews existed. It proves that the changes were made towards the amount of payment between communes.. In the current context, to ascertain the reliability of rountine financial reporting is incapable to carry out for the research team. Therefore, we suggest the audience to concentrate on the evaluation of project design and findings from household survey (costs for patients' care), rather than to find out about an adequate cost for implementing a project in a commune.

- To date, the study can end up with a conclusion that the project costs distributed to a commune were majorly spent on launching the baseline survey which was conducted by the provincial hospital. The maintenance costs for a commune health centre was not higher than 150 thousand VND per month (excluding medication cost). If an improvement in project management will be achieved, it is likely to understand factual costs to provide community management for all schizophrenic (in mild and more severe status) and epylepsic cases.

4- Project impacts and outcome indicators

- The project had inevitable impact on the accessibility of mental healthcare services. The prevalence of schizophrenia patients experienced inpatient treatment and examination services, as well as the length of treatment was significantly decreased.

- There was not much of a difference in the percentage of patients in the communitythat received professional psychiatric diagnoses and treatment between the commune groups with- and without- the project (80% in Ha Nam, 72% in Ha Tay, compared to 76% in the control group).

- The majority of cases seeking diagnosis and treatment at the national and provincial hospital of psychiatry are diagnosed with schizophrenia and epilepsy (these mental illnesses make up 73% of diagnoses in Ha Nam, 87% in Ha Tay, and 65% in the control group). This indicates that the majority of others, more common mental disorders (such as depression, anxiety, behavioral disorders…) do not receive adequate professional attention, diagnosis and treatment.

- The number of cases who had doubted mental abnomalities sought healthcare services did not differ between commune groups with the project (91% and 92% in Ha Nam and Ha Tay, respectively) and without the project (87%).

5- Benefits to community through public IEC on mental health

- The communes with the project model do not show significant improvement in terms of identifying new patients during the last five years. In addition, the impact of the project on patients' patterns of access to mental health care providers as well as on patients' families in retrieving education messages is not clear. The percentage of families getting education messages on mental health promotion was not statistically different between communes with and without project: less than 10% of households has never read printed materials on mental healthcare in communes with the project (9% in Ha Nam and 7% in Ha Tay, and under 5% in communes without project); and lower prevalence of households having the mental healthcare materials stored in their home or acquaitance's homes (4% in Ha Nam, <1% in Ha Tay)

- The policy of free drugs for schizophrenia and epilepsy patients is applied in both project and non-project communes, however in the communes with the project, patients can receive drugs at their own communes, while in the non-project communes, they are required to go to provincial hospitals of psychiatry for the collection of drugs.

6- Benefits to patients

The benefits to patients were recognized:

- The duration of care for inpatient treatment is significantly shorter in the project group (60 days for Ha Nam group, 68 for Ha Tay group and 90 days for control group). The project, through the provision of drugs and treatment, has reduced the severity of illnesses, especially schizophrenia.

- Apart from psychiatric medication, imprisonment measures to control the patients existed and made up of about 20-40% of the total patients. Psychotherapy, yoga exercises and meditation was rarely used.

- The costs of mental health care are not different between the groups with- and without the project.

In order to improve community-based mental health care services in Vietnam, the research team recommends that:

1- Improved model design

- To help the public and the health professionals better understand mental health care, the current model of "community-based mental health care" should introduce the common mental disorders to be managed by the project. This action will require a huge change in project objectives, bringing about the difference in possible resouces. If this current approach will be maintained for any reason, at least the title of the project should be renamed to be "Community-based care model for patients with schizophrenia and epilepsy" to avoid the misunderstanding of the citizens and primary health staff about the insights of mental health and mental health care.

- Strong support of international and national donors in mental healthcare in Vietnam should be encouraged.

- To design community mental health projects, the approach of preventative medicine must be applied, therefore:

    - Cost-effective interventions are insured: to achieve this objective, early detection and treatment should be promoted. It means that epidemiological tools for screening must be applied and the screening should be conducted at families, schools, commune health centres, and offices. To foster early treatment, a standard outpatient clinic to support the diagnosis and treatment planning implemented by the primary health workers and families should be established. The professional criteria of this type of clinics need to be built as soon as possible, and an establishment of standard clinics for counselling and treating mental disorders should be a priority.

    - The preventable and curable common mental disorders such as depression, anxiety, sleep problems and alcohol abuse, which account for 80% of total burden of mental health in community, should become the focus of community mental health care.

    - To build up the project, the direct beneficiaries such as people with mild mental disorders and illnesses, vulnerable population (pregnant women and having young children, people with HIV/AIDS, cancer, etc., their families and communities) should be targeted.

    - Creating an environment with less stigma and discrimination attached to mental sufferers becomes a key area of community mental health care

    - Psychotherapy and lifestyle rehabilitation should become the dominant strategy to addressing mental disorders at the grassroots level. The use of medication should be kept to a minimum, only to be used for severe cases.

    - Public education should become a key priority to foster the participation of community and primary health care system. Psychometric tools for screening probable cases of mental disorders should be popularly applied to develop evidence for early treatment and intervention.

- The community-based mental health care model should be developed based on evidence from cost-effectiveness studies conducted in Vietnam.

2- Community mental health training

- Building up a professional training program on community mental health, including training programs, training materials and training teams.

- The community mental health training program must be managed and run by a professional organization experienced in developing and implementing training programs.

- The national or provincial funds for training should be allocated to the professional organization which will in turn be responsible for the development of training programs and the provision of training in every community.

- IEC materials on mental health, particularly printed ones, should be distributed to familes and friends of patients.